TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ERWIN CRUZ, MD

Respondent Name
STARR INDEMNITY & LIABILITY CO

MFDR Tracking Number
M4-17-2605-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MAY 4, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid the claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $288.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "we have escalated the bill in question for manual review to determine if additional monies are owed."

Position Summary Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2016	Outpatient Medical Rehabilitation Program CPT Code 97799-MR (4 hours)	$288.00	$288.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.210, effective July 17, 2016, sets the reimbursement guidelines for Workers Compensation Specific Services.
3. 28 Texas Administrative Code §134.230, effective July 17, 2016 sets out the reimbursement guidelines for outpatient rehabilitation programs.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 15(150)-Payer deems the information submitted does not support this level of service.
   - 18-Duplicate claim/service.

Issues

1. Does the documentation submitted support billed service?

2. Is the requestor entitled to reimbursement for the outpatient medical rehabilitation program rendered on September 14, 2016?

Findings

1. According to the original explanation of benefits, the respondent denied reimbursement for the outpatient medical rehabilitation program based upon "15(150)-Payer deems the information submitted does not support this level of service". The requestor submitted a copy of outpatient medical rehabilitation notes that support billed service; therefore, the respondent's denial based upon "15(150)" is not supported, reimbursement is recommended.

2. To determine reimbursement the division refers to 28 Texas Administrative Code §134.210 and §134.230.

   28 Texas Administrative Code §134.210(e)(4) states "The following division modifiers shall be used by health care providers billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. 4) MR, outpatient medical rehabilitation program--This modifier shall be added to CPT code 97799 to indicate outpatient medical rehabilitation program services were performed."

   28 Texas Administrative Code §134.230 (4) states "The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs.

   (A) Program shall be billed and reimbursed using CPT code 97799 with modifier "MR" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited programs shall add "CA" as a second modifier.
   (B) Reimbursement shall be $90 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

   A review of the submitted medical notes support the 4 billed hours. The requestor billed for a non-CARF accredited program; therefore, 28 Texas Administrative Code §134.230 (1) (B) applies. 28 Texas Administrative Code §134.230 (1) (B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR." The division finds 80% of $90.00 = $72.00 X 4 hours = $288.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $288.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $288.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	6/07/2017 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812